CHAPTER 5
ADMINISTRATIVE FEATURES AND REGULATORY CONTROLS IN A MANAGED CARE SYSTEM

This Chapter provides an overview of the administrative features and regulatory controls which AHCCCS has implemented in the Medicaid and KidsCare programs. These functions are critical to the success of AHCCCS and allow the program to operate a fiscally responsible managed care program grounded in quality of care.

ADMINISTRATIVE FEATURES

Encounter Data Reporting

As a condition of the 1115 Waiver, CMS requires AHCCCS to submit specific information regarding services provided to Medicaid and KidsCare members. These records, known as encounter data, are submitted to AHCCCS for institutional, professional, dental and prescription drugs. AHCCCS requires all contractors (Health Plans for acute and Program Contractors for ALTCS) to submit encounter data through electronic media within 240 days after the end of the month in which the service was provided.

The purpose of encounter reporting is to:

- Evaluate health care quality and cost effectiveness
- Evaluate individual contractor performance
- Develop and evaluate capitation rates paid to the contractor
- Determine Disproportionate Share payments to hospitals
- Develop FFS payment rates
- Pay reinsurance to the contractor

AHCCCS performs annual validation studies on acute care, long-term care and behavioral health encounter data to ensure that the data reported is done timely, accurately and completely. Since sanctions may be imposed on the contractors based on the results of the data validation studies, AHCCCS provides the contractors with assistance and training.

Reinsurance

AHCCCS provides various types of reinsurance coverage to contractors. The purpose of reinsurance is to reduce the financial risk for significant medical expenses incurred by members.

<u>AHCCCS Inpatient Reinsurance</u>

AHCCCS inpatient reinsurance is available to reimburse AHCCCS acute care Health Plans for a portion of the costs of covered inpatient services. The deductible level for all rate codes and counties is based on the Health Plan's statewide AHCCCS acute care enrollment (excluding SOBRA Family Planning Extension services) as of October 1st of each contract year. The coinsurance percentage is the rate that AHCCCS reimburses the contracted Health Plan for covered inpatient services incurred over and above the deductible. The deductible is the responsibility of the Health Plan. Chart 5A details AHCCCS inpatient reinsurance.

Chart 5A

AHCCCS Inpatient Reinsurance

Statewide Plan Enrollment	**Prospective Reinsurance** *Title XIX Waiver Group Deductible*	*Non TXIX Waiver Deductible*	***Coinsurance***
0-34,999	$15,000	$20,000	75%
35,000-49,999	$15,000	$35,000	75%
50,000 and over	$15,000	$50,000	75%

Catastrophic Reinsurance

The reinsurance program also includes a special Catastrophic Reinsurance program. This program is for members diagnosed with Hemophilia, von Willebrand's Disease and Gaucher's Disease. There are no deductibles for catastrophic reinsurance cases. All medically necessary services provided during the contract year are eligible for reimbursement at 85 percent of the Health Plan paid amount unless the costs are paid under a subcapitated arrangement. In subcapitated arrangements, the Administration shall base reimbursement of reinsurance encounters on the AHCCCS allowed amount or the reported health plan paid amount, whichever is lower, minus the coinsurance and Medicare/TPL payment and applicable quick pay discounts. All catastrophic claims are subject to medical review by AHCCCS.

Transplants

This program covers members who are eligible to receive major organ and tissue transplantation including bone marrow, heart, heart/lung, lung, liver, kidney and other organ transplantation. Bone grafts and cornea transplantation services are not eligible for transplant reinsurance coverage, but are eligible under regular inpatient reinsurance. Reinsurance for transplants is limited to 85 percent of the AHCCCS contracted amount for the transplantation services rendered or 85 percent of the Health Plan paid amount, whichever is lower.

ALTCS Reinsurance

ALTCS regular reinsurance covers all medically necessary acute care services, outpatient hospital services and inpatient hospitalizations. The program has an initial deductible level and a subsequent coinsurance percentage. Prospective reinsurance coverage applies to claims incurred in a prospective enrollment period. The deductible level is based on the Program Contractor's statewide ALTCS enrollment as of October 1st of each contract year, as shown in Chart 5B.

Chart 5B

ALTCS Reinsurance

Statewide Plan Enrollment	***Prospective Reinsurance*** *With Medicare Part A*	*Without Medicare Part A*	*Coinsurance*	***PPC Reinsurance*** *All Members*	*Coinsurance*
0-1,999	$10,000	$20,000	75%	$5,000	100%
2,000 +	$20,000	$30,000	75%	$5,000	100%

High Cost Behavioral Health Reinsurance

Members considered by AHCCCS to be high-cost Behavioral Health or Traumatic Brain Injured are also covered under regular reinsurance using separate guidelines. Placement into an institutional or HCBS setting for these members must be approved in advance by AHCCCS for the Program Contractor to qualify for reinsurance reimbursement. Behavioral Health/Traumatic Brain Injury reinsurance covers the institutional or HCBS setting only. Except for regular and catastrophic reinsurance, acute care services and all other ALTCS services are not covered by reinsurance for this population. The Program Contractor will be reimbursed at 75 percent of allowable payments with no deductible unless the costs are paid under a subcapitated agreement. In subcapitated agreements, the Administration shall base reimbursement of reinsurance encounters on the AHCCCS allowed amount, or the reported Health Plan paid amount, whichever is lower, minus the coinsurance and Medicare/TPL payment and applicable quick-pay discounts.

Prepaid Medical Management Information System (PMMIS)

AHCCCS uses a statewide, automated managed care data system to meet the processing and reporting needs of prepaid, capitated programs and FFS claims. The system, known as Prepaid Medical Management Information System (PMMIS), is composed of eleven core subsystems, five reporting and quality oversight subsystems and a security subsystem. These subsystems are able to perform the following:

- Generate payments to Program Contractors, Health Plans, and providers
- Process enrollment and generate enrollment and capitation files to health plans and program contractors
- Maintain member data history and preserve data on encounters and claims
- Support case management and automated referrals
- Offer system information management
- Facilitate utilization review and quality management
- Provide for financial management and reporting
- Allow for reinsurance and quality control analyses

Acute Care - PMMIS

PMMIS provides extensive information, retrieval and reporting capabilities to satisfy the data needs of AHCCCS, CMS, other state and federal agencies, Health Plans, providers and members. The system processes both FFS claims and Health Plan encounters for all AHCCCS members, and supports the monitoring of service utilization, quality of care, and program expenditures.

ALTCS - PMMIS

PMMIS provides and receives information about ALTCS members after it has been updated from the long-term care eligibility system (ACE).

ACE captures and maintains financial eligibility information, enrollment, and discontinuance information.

ACE captures and maintains the detailed results of pre-admission screening and member demographics. Case managers input data into CATS regarding the cost effectiveness of placement options for HCBS, member placement data, service plans, and updates.

ACE has been rolled out to all 15 ALTCS eligibility offices, as well as the SSI-MAO office. The ACE system is the first major AHCCCS system to be developed off of the mainframe. It resides on an Oracle database, is developed in Visual Basic and runs off of terminal servers.

ACE is part of a larger business re-engineering project for ALTCS and SSI-MAO. Much of its design is based on input received from customer surveys and field office teams. ACE is an interactive interviewing system. By the end of an interview with an eligibility specialist, ACE produces the application for the applicant's signature, as well as other verification forms required in order to determine eligibility. ACE is designed based on Microsoft standards. It has no codes to enter, no screen numbers to memorize and utilizes many drop down lists to supply appropriate answers.

Development is underway for the conversion of KidsCare eligibility from the KidsCare Eligibility Determination System (KEDS) to the ACE system. That conversion is expected to occur in May 2006.

Health Insurance Portability and Accountability Act of 1996

The Health Insurance Portability and Accountability Act (HIPAA) changed certain aspects of the way health care is administered. President Clinton signed the Kassebaum-Kennedy Health Insurance Portability and Accountability Act on August 21, 1996.

HIPAA is designed to expand health coverage by improving the portability and continuity of health insurance coverage in group and individual markets to:

- Combat waste in health care delivery,
- Promote the use of medical savings accounts,
- Improve access to long-term care services and coverage, and
- Simplify the administration of health insurance.

Within this context, HIPAA includes a provision called Administrative Simplification, which is intended to improve the efficiency and effectiveness of the health care system by encouraging the development of standards for the electronic transmission, privacy and security of certain health information. Administrative Simplification is one of the Act's five titles and is a focus for governments across the nation.

The implementation of HIPAA led to a standardized format of our interface files with providers, Health Plans and Program Contractors. In addition, HIPAA defines the standard security requirements and enables AHCCCS to properly safeguard entrusted data as required by its federal business partners. The project was divided into two parts: Transactions and Code Sets, and Privacy and Security.

For Transactions and Code Sets, the requirements were implemented for both Arizona and Hawaii in October of 2003.

For Privacy and Security, all requirements were implemented.

Hawaii/Arizona Partnership

In 1999, Hawaii and Arizona have entered into an agreement to implement the PMMIS for the State of Hawaii Medicaid program through a joint effort between the Hawaii Department of Human Services and AHCCCS. Both states share the ongoing maintenance and operation of the system.

Co-payments

Co-payments may be requested from Medicaid members except when the member is under the age of 19, pregnant, enrolled as fee for service or Native American and enrolled with a Health Plan. Copayments are primarily used to control the inappropriate utilization of certain services by members. However, members cannot be denied services due to their inability to pay the copayment. In addition, copayments are not assessed for: family planning services; services to members residing in nursing facilities or Intermediate Care Facilities for the Mentally Retarded (ICF-MR); visits scheduled by a primary care provider which are not requested by the member or drugs/medications.

In 2003, the Arizona State Legislature instituted increased co-pays for certain AHCCCS members. In accordance with this legislative action, AHCCCS sought guidance from CMS to implement greater than nominal mandatory co-pays for Title XIX waiver groups. CMS informed AHCCCS that waiver authority was unnecessary but the cost sharing measures should be included in Arizona's Operational Protocols. When AHCCCS began implementation of these co-pays in the fall of 2003, a lawsuit was filed challenging the authority of AHCCCS to enforce the co-pays. A U.S. District Court issued an injunction and prevented implementation of cost sharing. To date, the injunction still governs in Arizona.

REGULATORY CONTROLS

In order to ensure the health of AHCCCS members and avoid problems encountered in earlier years of the program, AHCCCS has established regulatory controls designed to promote the delivery of the highest possible healthcare to members. AHCCCS reports the results of this initiative on a regular basis to CMS in compliance with the Special Terms and Conditions of the 1115 Research and Demonstration Waiver.

Based on mutual agreement between AHCCCS and CMS, the agency has undertaken a quality improvement initiative consisting of a variety of health care and financial indicators. The agency also submits to CMS utilization reports using data from encounters and claims. In addition, the agency implements a grievance and request for hearing process, a program for combating fraud and abuse, and conducts regular financial and operational reviews of all Health Plans and Program Contractors. The following is a description of the activities undertaken during the reporting period.

Quality Assessment and Performance Improvement

AHCCCS ensures that each contracted health plan (Contractor) has an ongoing quality assessment and performance improvement program for the services furnished to its members, consistent with regulations under the Balanced Budget Act (BBA) of 1997. Contractors submit encounter data to AHCCCS, which measures each plan's performance and evaluates its compliance in meeting contractual performance standards for specific health care services.

Acute-care Performance Measures

In CYE 2005, AHCCCS measured the performance of eight publicly and privately operated health plans in several preventive health care areas. In addition, performance of the Comprehensive Medical and Dental Program (CMDP), a health plan operated by the Arizona Department of Economic Security (DES) for children and adolescents in foster care, was evaluated for most of those measures.

The results reported here should be viewed as *indicators* of utilization of services, rather than absolute rates for how successfully AHCCCS and/or its Contractors provide care. Many factors affect whether AHCCCS members use services. By analyzing trends over time, AHCCCS and its Contractors have identified areas for improvement and implemented interventions to increase access to, and use of, services.

Methodology

AHCCCS uses the Health Plan Employer Data and Information Set (HEDIS®) as a guide for collecting and reporting results of these measures. Developed and maintained by the National Committee for Quality Assurance (NCQA), HEDIS is the most widely used set of performance measures in the managed care industry. The current measures utilize data for the contract year ending September 30, 2004.

One of the criteria for selecting members to be included in the analyses is that they be continuously enrolled for a minimum period of time with one Contractor. Thus, members included in the results of each measure represent only a portion of AHCCCS members, rather than the entire acute care population.

AHCCCS uses a statewide, automated managed care data system known as the Prepaid Medical Management Information System (PMMIS). Members included in the denominator for each measure are selected from the Recipient Subsystem of PMMIS. Numerators, and therefore rates, for each measure are based on AHCCCS encounter data; i.e., records of medically necessary services provided and the related claims paid by Contractors. The rates reported for each Contractor and the overall rates may be negatively affected if Contractors have not submitted complete and accurate encounters to AHCCCS for the period being measured.

Results

All acute-care measures except one improved in the most recent measurement period. Results by measure were as follows:

Measure	AHCCCS Current Rate (%)	Previous AHCCCS Rate (%)
Children's Access to PCPs – Medicaid	77.3	75.7
Children's Access to PCPs – KidsCare	79.1	77.7
Adults' Access to Preventive/Ambulatory Health Services – Medicaid	77.8	76.2
Well-child Visits in the First 15 Months of Life – Medicaid	66.9	68.4
Well-child Visits in the Third, Fourth, Fifth and Sixth Years of Life – Medicaid	56.4	51.5
Well-child Visits in the Third, Fourth, Fifth and Sixth Years of Life – KidsCare	61.0	56.7
Adolescent Well-care Visits – Medicaid	32.6	30.9
Adolescent Well-care Visits – KidsCare	37.2	34.6
Annual Dental Visits – Medicaid	53.9	48.5
Annual Dental Visits – KidsCare	63.5	57.8

- **Children's Access to PCPs** – Overall rates for both Medicaid and KidsCare members showed statistically significant increases and reached their highest levels since AHCCCS began measuring these rates.
- **Adults' Access to Preventive/Ambulatory Health Services** – This measure also increased by a statistically significant amount.
- **Well-child Visits in the First 15 Months of Life** – The overall rate for this measure showed a relative decline of 2.1 percent (the rate includes only Medicaid members, as most children in this age range qualify for AHCCCS under this program).
- **Well-child Visits in the Third, Fourth, Fifth and Sixth Years of Life** – Overall rates for both Medicaid and KidsCare members showed statistically significant increases and reached their highest levels.

- **Adolescent Well-care Visits** – Overall rates for both Medicaid and KidsCare members showed statistically significant improvements from the previous measurement period.
- **Annual Dental Visits** – Rates for this measure also improved significantly, reaching their highest levels ever for both Medicaid and KidsCare members.

Compared with the most recent national HEDIS means (averages) reported by NCQA for Medicaid health plans, AHCCCS Medicaid rates were higher than the national means for some measures and lower for others. Most notably, the AHCCCS Medicaid rates for Well-child Visits in the First 15 Months of Life and Annual Dental Visits were well above the HEDIS national Medicaid averages for these measures. Despite the small decline in the current measurement period, the rate for Well-child Visits in the First 15 Months of Life was equivalent to the most recent HEDIS average for commercial health plans, which is much higher than the Medicaid average.

Consistent with previous measurements, children enrolled with AHCCCS Contractors through KidsCare have higher overall rates of preventive services than those enrolled under Medicaid. Depending on their incomes, parents of KidsCare members may pay a premium for coverage and thus may be more likely to ensure that their children receive covered benefits, including well-care visits. These parents also may have a higher level of education and a better understanding of the value of preventive health care services.

Performance Standards and Improvement

AHCCCS has established performance standards for contracted health plans for these measures. Contractors should meet the AHCCCS Minimum Performance Standard for a particular measure and should try to achieve higher goals established by the agency. Since the last report of these measures, AHCCCS has raised Minimum Performance Standards in order to encourage Contractors to continue improving their rates.

AHCCCS requires corrective action plans from Contractors that do not meet the Minimum Performance Standard for any measure, or that show a statistically significant decline, even if they met the minimum standard. Contractors that fail to show improvement may be subject to sanctions. Some Contractors already have corrective action plans in place for Children's Access to PCPs and Adults' Access to Preventive/Ambulatory Health Services. On an ongoing basis, AHCCCS will monitor Contractor rates for each measure, especially for those plans that have not met Minimum Performance Standards.

AHCCCS will continue to provide technical assistance, such as identification of new interventions or enhancements to existing efforts, to help Contractors improve their performance. For example, AHCCCS began leading a collaborative effort that includes Contractors and some community agencies in early 2004 to improve well-child visits among children three through six years of age and to support health-related goals of the Governor's School Readiness Board. It appears that this focused effort has contributed to improvements in the rate of well-child visits among this age group during the most recent measurement period. In order to continue improvements in this area and meet AHCCCS goals, the agency has researched evidence-based strategies for improving well-child visits and is working with Contractors to identify and implement a new standardized intervention.

ALTCS Performance Measures

- **Diabetes Care**

AHCCCS used HEDIS specifications as a guideline for measurement of diabetes care services provided to elderly and physically disabled (E/PD) members. Three indicators, Hb A_{1c} testing, lipid screening and retinal exams were measured.

Methodology

This study measured services provided from October 1, 2003, through September 30, 2004. It included a representative, random sample of ALTCS members diagnosed with Type 1 or Type 2 diabetes, who were 18 through 75 years of age, and were continuously enrolled with one ALTCS Contractor for the entire measurement period (one gap in enrollment, not exceeding 31 days, was allowed).

This study differs from previous measures of diabetes preventive care services conducted by AHCCCS. In the two prior measurements, results were based on administrative data only and consisted of a combination of AHCCCS encounter data and analytic data obtained from the Centers for Medicare and Medicaid Services (CMS). The previous results were obtained and analyzed by Health Services Advisory Group (HSAG), an independent Quality Improvement Organization, through a collaborative agreement. AHCCCS undertook this collaborative project with HSAG to collect data on diabetes care services for members who were dually enrolled in Medicaid and Medicare. However, data on services provided to dually enrolled members through Medicare managed care plans was not available from CMS. In order to collect more complete data for the diabetes Performance Measures, AHCCCS began using the current hybrid data collection process, beginning with this measurement.

Results

Hb A_{1c} testing – AHCCCS measured the percentage of members who had one or more glycosylated hemoglobin, or Hb A_{1c}, tests during the measurement period. The overall rate of ALTCS members with diabetes who received one or more Hb A_{1c} tests was 76.7 percent.

Lipid (LDL) screening – AHCCCS measured the percentage of members who had one or more fasting lipid profiles performed during the measurement period or the preceding year. The overall rate of lipid screening during the measurement period or the preceding year was 69.2 percent.

Retinal exams – AHCCCS measured the percent of members who had a retinal exam by an optometrist or ophthalmologist during the measurement period or the preceding year. The overall rate of members with retinal exams was 50.1 percent.

Performance Standards and Improvement

All Contractors are meeting the current AHCCCS Minimum Performance Standards for diabetes care and most have exceeded current goals. Compared with the most recent HEDIS data for Medicaid health plans, most ALTCS Contractors exceeded national averages for Hb A_{1c} testing and eye exams. It also should be noted that some AHCCCS Contractors are achieving rates of diabetes preventive care services that are comparable with HEDIS commercial health plan averages.

In order to assist ALTCS Contractors with performance improvement efforts, AHCCCS has compiled information on barriers to effective diabetes management and successful strategies for increasing the use of preventive-care practices. AHCCCS is continuing to work with Contractors to improve performance in these indicators.

- **Home and Community Based Services (HCBS)**

AHCCCS measured the percentage of newly placed HCBS members who received selected services within 30 days of enrollment. Examples of these services include adult day health care, attendant care, home-delivered meals, home health nursing and homemaker assistance.

Methodology

The study covered the measurement period from October 1, 2003, through September 30, 2004. A representative random sample was selected for each Contractor. Data were first collected from AHCCCS encounter data. When services within 30 days of enrollment for a particular member were not found in AHCCCS encounter data, Contractors were asked to provide service delivery information from medical or case management records, or their claims data.

To validate additional information collected by Contractors, AHCCCS required documentation of services provided or reasons why a member did not receive services (for example, the member refused services while waiting for a family member to become trained to provide attendant care or was hospitalized during all or part of the first 30 days of enrollment). Documentation provided by Contractors

included copies of the pertinent sections of case management records, medical/service records from providers, or verification of claims paid by Contractors for qualifying services.

Results
The overall rate of initiation of services was 89.2 percent, a statistically significant improvement from the rate of 83.7 percent in the previous measurement period.

Performance Standards and Improvement
All seven ALTCS Contractors exceeded the AHCCCS Minimum Performance Standard in the current measurement period.

Given the variety and complexity of members' needs and personal situations when they enroll in the ALTCS program, Contractors' case managers face distinct challenges in ensuring that enrollees have prompt access to home and community based services that fit with their individual choices. These services are designed to help long-term care recipients maintain or improve their health and functional status, and enjoy a greater degree of independence. AHCCCS Contractors are effectively meeting this challenge, with some health plans achieving rates of 90 percent or better for this measure.

Performance Improvement Projects (PIPs)

In addition to Performance Measures, AHCCCS requires Contractors to conduct Performance Improvement Projects (PIPs), as defined under BBA regulations. These PIPs are designed to achieve, through ongoing measurements and intervention, significant improvement that is sustained over time. PIPs may be conducted in clinical or nonclinical areas that are expected to have a favorable effect on member health outcomes and satisfaction. Contractors design and conduct their own PIPs, and are required to participate in at least one AHCCCS-designed and mandated PIP.

- **Management of Diabetes**

One of the mandated PIPs under way is designed to assist diabetic members and their physicians with establishing and maintaining control of blood-glucose (glycemic) levels, in order to prevent or minimize complications of the disease. This PIP, implemented in CYE 2002, measures annual Hb A_{1c} testing and laboratory levels of selected members.

In CYE 2005, AHCCCS conducted a remeasurement of performance to determine whether Contractors that showed a statistically significant improvement from the baseline measurement to the first remeasurement had sustained that improvement for an additional year. In the first remeasurement, 14 of 15 Acute-care and ALTCS Contractors demonstrated improvement from the baseline measurement and/or were performing at the optimal benchmark established by AHCCCS. All of those Contractors sustained that level of performance in the second remeasurement. The remaining Contractor demonstrated improvement in the second remeasurement, and will continue participating in this PIP until it shows sustained improvement.

- **Children's Oral Health**

The purpose of this AHCCCS-mandated PIP is to increase the rate of annual dental visits among children enrolled in AHCCCS. This project specifically focuses on children who are 3 through 8 years old, as this appears to be a critical time in a child's life to ensure that he or she receives regular dental care. Contractors participating in this PIP include acute-care health plans, CMDP, DDD and ALTCS health plans that serve elderly and physically disabled members.

All Acute-care Contractors except one showed statistically significant increases from the baseline measurement and/or exceeded the goal of 57 percent. DDD also achieved a significant improvement in its rate.

Because of a relatively small number of physically disabled children enrolled with other ALTCS Contractors, AHCCCS measured annual dental visits among members 3 through 20 years of age for this group. Overall, there was no significant change from the previous measurement. Data for physically disabled members was not analyzed by individual Contractor because most ALTCS health plans did not have enough members to make statistical comparisons.

AHCCCS will conduct a second remeasurement of this PIP in 2006.

Financial Viability Standards

AHCCCS has established financial and operational standards that all Health Plans and Program Contractors (referred to in this section as Contractors) must meet. Based on these standards, AHCCCS and the Contractors examine profitability and administrative performance issues through an analysis of four financial viability standards. The following is a brief explanation of each standard and the Health Plan results of the most recent financial audits conducted.

Current Ratio

This standard measures whether a Contractor can pay current obligations as they come due. Results show that all Contractors for which there was data, met the standard.

Equity per member

This standard measures a Contractor's ability to withstand adverse utilization over a one-year period. Results show that all Contractors for which there was data, met this standard.

Medical Expense Ratio

This standard shows how well a Contractor manages care. If it is too low, under-utilization of services may be a problem. If it is too high, the Contractor may be managing care inappropriately. All Contractors for which there was data met the medical loss ratio standard.

Administrative Cost Percentage

This standard measures the percentage of AHCCCS capitation premiums spent on non-medical expenses. All Contractors for which there was data met the administrative cost percentage standard.

Days Outstanding Received but Unpaid Claims

This standard shows if claims are being paid in a timely fashion. This standard may suggest cash flow problems if Contractors are slow in paying bills. All Contractors for which there was data met this standard.

In addition to the four financial viability standards mentioned above, AHCCCS monitors, on a minimum quarterly basis, the operating income or loss of the Contractors as well as the Incurred but Not Reported (IBNR) claims estimates. The IBNR estimates the dollar amount of claims for which the Contractor has provided the service but has not received the actual claim.

Grievance System

The Office of Legal Assistance (OLA) provides legal counsel to the AHCCCS administration, is responsible for the Agency rulemaking process, and oversees the Grievance System for the AHCCCS Program. Major components of the Grievance system include, scheduling State Fair Hearings for disputed matters, the informal adjudication of member appeals and provider claim disputes, and the issuance of AHCCCS Hearing Decisions subsequent to Recommendations made by Administrative Law Judges.

During the last year, OLA received 8,941 matters, including member appeals, provider claim disputes, ALTCS trust reviews and eligibility appeals. OLA issued 4,005 Director's Decisions after State Fair hearings were held. OLA was able to resolve 5,783 cases at the informal level, alleviating the need for a State Fair Hearing. Of the 8,941 total cases received by OLA, 736 were member appeals, 5,667 were provider claim disputes, 455 were ALTCS trust reviews and 2,083 were eligibility appeals.

Fraud and Abuse

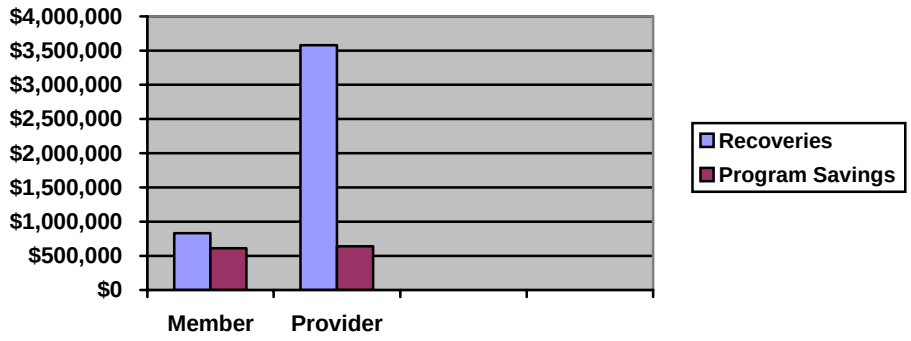
The AHCCCS Office of Program Integrity (OPI) is responsible for combating fraud and abuse in the Arizona Medicaid program. OPI consists of three Units: Audits, Member Fraud and Provider Fraud. OPI has developed a comprehensive approach that focuses on strengthening program safeguards, assessing areas of potential vulnerability and investigating allegations of fraud and abuse.

OPI visited AHCCCS Contractors on-site to discuss the development of formal compliance programs. In light of the new requirements and to promote development of effective compliance programs over the next year, OPI has worked with the Division of Health Care Management to strengthen contracts by requiring the formation of Compliance Committees and written criteria for selecting a Compliance Officer. OPI also participates in all the scheduled Operational and Financial Reviews to further strengthen the Fraud Waste and Abuse program. The AHCCCS fraud and abuse policy was revised in October 2003 to incorporate the requirement for Compliance Officers and the reporting of potential/suspected fraud and abuse within 10 working days of the discovery of the incident.

OPI continues to host fraud and abuse work group meetings, now called "Compliance Officer Network Group" meetings. Subjects include program safeguards designed to limit abuse and diversion of prescription drugs by AHCCCS members and discussions on any methods to strengthen and improve efforts to prevent, detect and report fraud and abuse in the State's Medicaid Program. Additionally, the Director of Program Integrity and the Director of the Medicaid Fraud Control Unit of the Attorney General's Office have conducted several joint fraud awareness presentations to AHCCCS Contractors.

A major behavioral health audit was conducted during 2005 by OPI's Office of Audit Services (OAS). Specifically the OAS chose two Regional Behavioral Health Authorities (RHBAs) and one of their providers. The audit was generated from a concern about improper coding for services based on an investigation conducted by OPI on a RHBA and their provider. The results of the audit will be finalized during 2006. The Audit Unit routinely utilizes the "Medicare Fraud Alerts" to determine if the AHCCCS program is vulnerable to the schemes identified in the Alerts.

Chart 5C
Program Integrity Activity



For the year, OPI had total savings and recoveries of $5,662,848 (see Chart 5C) and six criminal convictions.

Recoveries are monies actually received by AHCCCS from OPI investigations, settlement agreements, convictions and court orders. Program Savings are monies identified by an OPI investigation as an overpayment and recovered by a Health Plan, recovered by AHCCCS-OPI on behalf of a Health Plan or money saved by early detection of fraudulent enrollment and removal from the AHCCCS program. Cost Avoidance means the identification of future savings to the agency if recommendations are followed.

Following an investigation lasting 3 ½ years in southern Arizona and a two week trial, the owner of a non-emergency transportation company was found guilty of eight felony counts of fraud, theft, and money laundering for "padding" the mileage charged to AHCCCS for transporting members. The defendant was sentenced to 29½ years in prison, but because of concurrent sentences will only spend a total of five years behind bars. He was ordered to pay restitution of $189,989.15 to two AHCCCS contracted health plans. In addition, the Arizona Attorney General's Medicaid Fraud Control Unit (MFCU) used civil racketeering remedies to obtain a forfeiture judgment against the Defendant for $1,245,251.50.

A licensed pharmacist, working for Smith's Food and Drugs in Bullhead City, AZ, diverted 16,000 doses of prescription drugs, totaling $291,201.26, which was billed to AHCCCS and other medical insurance companies. No local law enforcement agencies or the local County Attorney's Office were interested in prosecuting the case. The AHCCCS Office of Program Integrity (OPI), with the assistance of the Arizona Attorney General's Office (MCFU Unit), investigated and prosecuted the case. The Defendant pleaded guilty to two felonies, theft and illegally acquiring narcotic drugs. He was sentenced to one year in jail, restitution of $151,000, $2,000 in fines and surcharges, 360 hours of community service, five (5) years probation, revocation of his pharmacy license and he cannot work in any capacity in a pharmacy until the end of his probation.

A Member Fraud investigation was predicated on information supplied by a physician who was renting a home from an AHCCCS member. The member presented an AHCCCS identification card when she went to him for services. This case was investigated and settled; the member paid AHCCCS $50,000.00 in restitution.

Financial and Operational Reviews

AHCCCS requires that all Health Plans, Program Contractors and ADHS and its subcontracted RBHAs adhere to standards expressly stated in their contract with AHCCCS. Health Plans, Program Contractors and RHBAs may not prosper by underserving enrolled members. Therefore, each Health Plan, Program Contractor and RBHA must:

- Disclose ownership and related third party transactions;
- Post performance bonds for insolvency protection;
- Prepare contingency plans in the event of insolvency;
- Meet stringent financial management standards established by AHCCCS; and
- Contract for an annual certified audit performed by a certified public accountant.

AHCCCS completes operational and financial reviews of Health Plans, Program Contractors and ADHS Behavioral Health Services. These site visits review contractors' general administration, and generally include:

- Business continuity plans;
- Cultural competency compliance;
- Staffing;
- Corporate compliance;
- Quality management processes, including provider credentialing;
- Handling of quality of care issues and complaints;
- Care coordination and case management processes;
- The delivery of maternal and child health services;
- The grievance system;
- The delivery system;
- Member services/ member rights;
- Reinsurance;
- Finances;
- Claims processing and payment;
- Encounter processing and submission; and
- Behavioral health coordination.

Teams representing various AHCCCS divisions perform the reviews. This integrated approach allows AHCCCS to maintain a comprehensive understanding of contractor activities, ensure effective contract compliance and delivery of services to members and in the event of deficiencies, provide technical assistance to resolve the problem and ensure that it will not reoccur.